

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 11/15/01.
 - b. The request was received on 05/15/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Position statement located on the Table of Disputed Services
 - b. HCFA-1500
 - c. TWCC-62 forms
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. Response to a Request for Dispute Resolution
 - b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The case file does not contain a carrier sign sheet. The carrier did submit an initial response dated 05/17/02. All information in the case file will be reviewed and considered timely.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
"Fair and reasonable according to other ins. [sic] carrier's [sic] EOB'S [sic]."
2. Respondent: Letter dated 05/17/02
"... (Provider) billed for his services under Code 01999 which requires documentation of procedure (DOP)... The use of CPT Code 01999 is also appropriate when the health care provider performs an anesthesia procedure(s) which is not listed in the CPT Codes for anesthesia set out in the Anesthesia Ground Rules of the 1996 Texas Workers' Medical Fee Guideline. The use of CPT Code 01999 for an unlisted anesthesia procedure requires the health care provider to comply with the General Instructions Section III – Documentation of Procedure of the ... Fee Guideline. (Provider) has failed to properly document the services and treatments for which he has billed."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/15/01.
2. Per the provider's TWCC-60, the amount billed is \$200.00; the amount paid is \$100.00; the amount in dispute is \$100.00.
3. The carrier denied the additional reimbursement amount by exception codes:
 "M – NO MAR";
 "646 – CHARGE IN EXCESS OF UNIT VALUE OR REASONABLE ALLOWANCE";
 "N – Not appropriately documented";
 "096 – INVALID SERVICE/CPT/DRG CODE. PLEASE RESUBMIT WITH VALID CODE."
4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Codes	MARS	REFERENCE	RATIONALE:
11/15/01	01999	\$200.00	\$100.00	M,N, 646, 096	DOP	MFG AGR (I) (B), (C); MFG GI (III); Rule 133.307 (g) (3) (D); 133.307 (g) (3) (B); CPT descriptor	MFG AGR (I) (B) states, "The total anesthesia value (TAV) for each procedure is defined by a basic value, which is related to the complexity of the service, plus modifying units (if any), plus time units". The provider failed to document the total TAV for CPT code 01999. The provider failed to submit documentation of procedure. There was no operative report or anesthesia report in the dispute packet. Per Rule 133.307 (g) (3) (B), the provider did not submit any medical documentation to substantiate that the service was performed as billed. Rule 133.307 (g) (3) (D) states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title...." As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider failed to submit documentation to establish that the payments made by the carrier were not fair and reasonable. No additional reimbursement is recommended.
Totals		\$200.00	\$100.00				The Requestor is not entitled to additional reimbursement.

MDR: M4-02-3685-01

The above Findings and Decision are hereby issued this 21st day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm